

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018982
2417 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED MAY 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran		d. STREET ADDRESS 6514 1/2 Independence Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE McKINLEY HODSON		4. DATE OF DEATH Month May Day 3 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/2/1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel	
11. BIRTHPLACE (City and state or country) Everton Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME David Hodson		13b. MOTHER'S MAIDEN NAME Mary Ellen Maxwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Vivian Williams		Address 124 So Ash Indep Mo	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 2. myocardial insufficiency DUE TO (c) Cause of Cirrhosis Not Known		INTERVAL BETWEEN ONSET AND DEATH known about 6 mo. 4 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour [REDACTED] a.m. [REDACTED] p.m. Month, Day, Year [REDACTED]		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION [REDACTED] COUNTY [REDACTED] STATE [REDACTED]	
21. I attended the deceased from March 1962 to May 3, 1962 and last saw her alive on May 2, 1962 Death occurred at Trinity Lutheran 2 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE J. Farnsworth M.D. (Degree or title)	
22b. ADDRESS 1103 Grand ave K.C. MO		22c. DATE SIGNED 5/3/62 (Date)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/5/1962	23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cem.	
23d. LOCATION (City, town, or county) Independence Mo		25. DATE RECD. BY LOCAL REG. 5-3-62	
24. FUNERAL DIRECTOR Sheil Funeral Home K C Mo ADDRESS [REDACTED]		26. REGISTRAR'S SIGNATURE Ruth Long	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.